Complete Summary

GUIDELINE TITLE

Clinical practice guideline for the assessment and prevention of falls in older people.

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Nursing and Supportive Care. Clinical practice guideline for the assessment and prevention of falls in older people. London (UK): National Institute for Clinical Excellence (NICE); 2004 Jun. 185 p.

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Fall risk

Note: Conditions that are not covered in this guideline are as follows.

- Osteoporosis (prevention and treatment), which is the subject of a separate NICE guideline under development. However, the parallel importance of both falls and bone health as risk factors for fracture has led to a degree of liaison in the preparation of both guidelines and will in practice require a coordinated approach to service delivery.
- Hip and other fractures (management)
- Falls in acute settings (prevention)

GUIDELINE CATEGORY

Counseling
Prevention
Risk Assessment

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine
Nursing
Physical Medicine and Rehabilitation
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Emergency Medical Technicians/Paramedics
Health Care Providers
Hospitals
Nurses
Patients
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To evaluate and summarize the evidence for assessing and preventing falls in older people
- To highlight gaps in the research evidence
- To formulate evidence-based and, where possible, clinical practice recommendations on the assessment of older people and prevention of falls in older people based on the best evidence available to the Guideline Development Group
- To provide audit criteria to assist in the implementation of the recommendations

TARGET POPULATION

- Older people (aged 65 and over) in the community or extended care who are at risk of falling or who have fallen
- Older people who attend primary or secondary care settings following a fall

Note: The guideline does not cover hospitalised patients who sustain a fall while in hospital or who may be at risk of falling during hospitalisation or people who are confined to bed for the long term.

INTERVENTIONS AND PRACTICES CONSIDERED

Risk Assessment and Identification

1. Identification of falls history
2. Assessment of gait, balance and mobility, and muscle weakness
3. Assessment of osteoporosis risk
4. Assessment of the older person's perceived functional ability and fear relating to falling
5. Assessment of visual impairment
6. Assessment of cognitive impairment and neurological examination
7. Assessment of urinary incontinence
8. Assessment of home hazards
9. Cardiovascular examination
10. Medication review

Multifactorial Interventions

1. Strength and balance training
2. Home hazard modification
3. Psychotropic medication modification/withdrawal
4. Cardiac pacing
5. Vision referral as a component of a multicomponent falls prevention program

Patient, Carer, and Healthcare Professional Education

1. Participation in falls prevention programs
2. Provision of information in languages other than English
3. Provision of information to patients and carers on how to cope if patients have a fall, including how to summon help and how to avoid a long lie
4. Maintenance of basic professional competence in falls assessment and prevention by healthcare professionals

Interventions Considered but Not Recommended

1. Low intensity exercise combined with incontinence programmes, group exercise, cognitive/behavioural interventions, referral for correction of visual impairment as a single intervention, vitamin D supplementation, brisk walking, hip protectors. Podiatric interventions were in the scope of the guideline; however, no controlled trials were identified with falls as an outcome.

MAJOR OUTCOMES CONSIDERED

Key questions addressed by the evidence reviews include the following:

- What is the best method of identifying those at highest risk of a first or subsequent fall?
- What assessment tools (or process) should be used to identify modifiable risk factors for falling?

- What are the most clinically effective and cost-effective methods for fall prevention?
- What is the best method for maximizing participation and compliance in falls prevention programs and modification of specific risk factors (e.g., medication withdrawal/review)?
- Are falls prevention programs acceptable to patients?
- What is the best method of rehabilitation/intervention/process of care following a fall requiring treatment?

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases
Searches of Unpublished Data

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

After formulating the questions to be addressed by evidence reviews (see "Major Outcomes Considered"), the Guideline Development Group (GDG) identified and evaluated potential evidence for each question, utilising the updated Cochrane reviews on preventing falls in older people and hip protectors, the American Geriatric Society/British Geriatrics Society (AGS/BGS) clinical guidelines, and the Shekelle systematic review. The GDG undertook systematic reviews on guideline areas not covered by the Cochrane review, AGS/BGS guidelines, or the Shekelle review.

Additionally, in December 2002, Stakeholders registered with the National Institute for Clinical Excellence (NICE) (see Appendix D in the original guideline document for a list of registered stakeholders) were invited to submit a list of evidence for consideration to ensure that relevant material to inform the evidence base was not missed. Submitted material received included notification of published, unpublished, and ongoing research related to falls prevention. All references were screened for relevance and design criteria and those considered eligible were checked with the GDG's databases to ensure the search had captured such studies.

See sections 5.2 to 5.14 in the original guideline document for detailed information about the specific methods for each evidence review.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Evidence Categories

I: Evidence from meta-analysis of randomised controlled trials or at least one randomised controlled trial

II: Evidence from at least one controlled trial without randomization or at least one other type of quasi-experimental study

III: Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case-control studies

IV: Evidence from expert committee reports or opinions and/or clinical experience of respected authorities

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The Guideline Development Group extracted relevant data from studies meeting methodological and clinical criteria. They interpreted each paper taking into account the results, including, where reported, the beneficial and adverse effects of the interventions, cost, and acceptability to patients; level of evidence; quality of studies; size and precision of effect; and relevance and generalisability of included studies to the scope of the guideline. They then prepared evidence reviews and tables which summarised and graded the body of evidence.

See sections 5.2 to 5.14 in the original guideline document for detailed information about the methods used for each evidence review.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The guideline recommendations were developed by a multidisciplinary and lay Guideline Development Group (GDG) convened by the National Institute for Clinical Excellence (NICE)-funded National Collaborating Centre for Nursing and Supportive Care (NCC-NSC) with members approved by NICE. Members include representatives from nursing, general practice, allied health, National Service Framework (NSF) Working Party, falls researchers, falls clinicians, and patient groups. The GDG met eleven times between September 2002 and May 2004.

In order for the GDG to formulate a clinically useful recommendation, it was agreed that the following factors be considered:

- The best evidence with preference given to empirical evidence over expert judgement where available, including:
    - Results of economic modeling
    - Effectiveness data taking into account the strength of evidence (the level, quality, precision) as well as the size of effect and relevance of the evidence
    - Where reported, data regarding additional outcomes such as adverse events, patient acceptability, and patient views
    - A comparison between the outcomes for alternative interventions where possible
- The feasibility of interventions, including where available, the cost of the intervention, acceptability to clinicians, patients and carers, and appropriateness of intervention
- The balancing of benefits against risks, including, where reported, all patient-relevant endpoints and the results of the economic modeling
- The applicability of the evidence to groups defined in the scope of the guideline, having considered the profile of patients recruited to the trials

This information was presented to the group in the form of evidence tables, accompanying evidence summaries and evidence statements (with associated level of evidence grading). Interpretations of the evidence were discussed at GDG meetings. Where the GDG identified issues which impacted on considerations of the evidence and the ability to formulate "implementable" and pragmatic guideline recommendations, these have been summarised in the "GDG commentary" sections under each recommendation in the original guideline document (though not all recommendations required a "GDG commentary" section).

Issues relating to interpretation of the evidence and the wording of recommendations were discussed by the GDG until there was agreement on the wording and grading of recommendations.

Where the GDG decided that "hard" evidence was essential before any recommendations could be considered, recommendations for future research were made using the National Institute for Clinical Excellence (NICE) guidance on formulating recommendations.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendation Grades

Grade A - Directly based on category I evidence

Grade B - Directly based on category II evidence or extrapolated recommendation from category I evidence

Grade C - Directly based on category III evidence or extrapolated recommendation from category I or II evidence

Grade D - Directly based on category IV evidence or extrapolated recommendation from category I, II, or III evidence

Good Practice Point (GPP) - Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)

COST ANALYSIS

To fulfill the Department of Health (DoH) and Welsh Assembly Government remit, the National Institute for Clinical Excellence (NICE) requested that the cost-effectiveness evidence of interventions for the assessment and prevention of falls in older people be assessed. In accordance with the objectives of the scope, cost effectiveness was addressed in the following way:

- A comparison of the cost and cost effectiveness of falls prevention interventions compared with usual care, other intentions or no intervention
- An investigation of which types of falls prevention programmes are the most cost effective

The aim of the review was two-fold. Firstly to identify economic evaluations that had been conducted alongside trials, but also to identify evidence that could be used in cost-effectiveness modelling.

See Section 5.11 in the original guideline document for methods and results of the cost-effectiveness review.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Draft guidelines were sent to stakeholders registered with National Institute for Clinical Excellence (NICE) and an expert peer reviewer identified by the National Collaborating Center for Nursing and Supportive Care. Non-registered stakeholders may also review the draft version of the guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Levels of evidence (I-IV) and grading of recommendations (A-D and GPP) are defined at the end of the "Major Recommendations" field.

Case/Risk Identification

C - Older people in the care of healthcare professionals should be asked routinely whether they have fallen in the last year and asked about the frequency, context, and characteristics of the fall.

C - Older people reporting a fall or considered at risk of falling should be observed for balance and gait deficits and considered for their ability to benefit from

interventions to improve balance and mobility. (Tests of balance and gait commonly used in the UK are detailed in the original guideline document.)

Multifactorial Falls Risk Assessment

C - Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls assessment of risk. This assessment should be performed by a healthcare professional or professionals with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualised, multifactorial intervention.

C - Multifactorial assessment may include the following:

- Identification of falls history
- Assessment of gait, balance and mobility, and muscle weakness
- Assessment of osteoporosis risk
- Assessment of the older person's perceived functional ability and fear relating to falling
- Assessment of visual impairment
- Assessment of cognitive impairment and neurological examination
- Assessment of urinary incontinence
- Assessment of home hazards
- Cardiovascular examination and medication review

Multifactorial Interventions

A - All older people with recurrent falls or assessed as being at increased risk of falling should be considered for an individualised multifactorial intervention.

A - In successful multifactorial intervention programmes the following specific components are common (against a background of the general diagnosis and management of causes and recognised risk factors):

- Strength and balance training
- Home hazard assessment and intervention
- Vision assessment and referral
- Medication review with modification/withdrawal

A - Following treatment for an injurious fall, older people should be offered an assessment to identify and address future risk and individualised intervention aimed at promoting independence and improving physical and psychological function.

Strength and Balance Training

A - Strength and balance training is recommended. Those most likely to benefit are older community-dwelling people with a history of recurrent falls and/or balance and gait deficit. A muscle strengthening and balance programme should

be offered. This should be individually prescribed and monitored by an appropriately trained professional.

Exercise in Extended Care Settings

A - Multifactorial interventions with an exercise component are recommended for older people in extended care settings who are at risk of falling.

Home Hazard and Safety Intervention

A - Older people discharged from hospital following a fall should be offered a home hazard assessment and safety intervention/modifications by a suitably trained healthcare professional. This should normally be part of discharge planning and be carried out within a timescale agreed by the patient or carer and appropriate members of the healthcare team.

A - Home hazard assessment is shown to be effective only in conjunction with follow-up and intervention, not in isolation.

Psychotropic Medications

B - Older people on psychotropic medications should have their medication reviewed, with specialist input if appropriate, and discontinued if possible to reduce their risk of falling.

Cardiac Pacing

B - Cardiac pacing should be considered for older people with cardioinhibitory carotid sinus hypersensitivity who have experienced unexplained falls.

Encouraging the Participation of Older People in Falls Prevention

D - To promote the participation of older people in falls prevention programmes the following should be considered:

- Healthcare professionals involved in the assessment and prevention of falls discussing which changes a person is willing to make to prevent falls.
- Information should be relevant and available in languages other than English.
- Falls prevention programmes should also address potential barriers such as low self-efficacy and fear of falling and encourage activity change as negotiated with the participant.

D - Practitioners who are involved in developing falls prevention programmes should ensure that such programmes are flexible enough to accommodate participants' different needs and preferences and should promote the social value of such programmes.

Education and Information Giving

D - Healthcare professionals involved in falls prevention should be educated about falls assessment and prevention.

D - Individuals at risk of falling and their carers should be offered information orally and in writing about:

- What measures they can take to prevent further falls
- How to stay motivated if referred for falls prevention strategies that include exercise or strength and balancing components
- The preventable nature of some falls
- The physical and psychological benefits of modifying falls risk
- Where they can seek further advice and assistance
- How to cope if they have a fall, including how to summon help and how to avoid a long lie

Definitions:

Evidence Categories

I: Evidence from meta-analysis of randomised controlled trials or at least one randomised controlled trial

II: Evidence from at least one controlled trial without randomization or at least one other type of quasi-experimental study

III: Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies, and case–control studies

IV: Evidence from expert committee reports or opinions and/or clinical experience of respected authorities

Recommendation Grades

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Good Practice Point (GPP) - Recommended good practice based on the clinical experience of the Guideline Development Group (GDG)

CLINICAL ALGORITHM(S)

A clinical algorithm is provided in a companion document for "Patient Referral and Care Pathway." See "Availability of Companion Documents" field.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Implementation of the recommendations may ensure that older people at risk from falls receive consistent management and care to prevent the occurrence of falls, improve outcomes, and minimize recurrence of injury due to falls.

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- As with any clinical guideline, recommendations may not be appropriate for use in all circumstances. A limitation of a guideline is that it simplifies clinical decision-making. Decisions to adopt any particular recommendations must be made by the practitioners in the light of:
    - Available resources
    - Local services, policies, and protocols
    - The patient's circumstances and wishes
    - Available personnel and devices
    - Clinical experience of the practitioner
    - Knowledge of more recent research findings.
- Healthcare professionals should use their clinical judgement and consult with patients when applying the recommendations which aim at reducing the negative physical, social, and financial impact of falling.
- This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

General

Local health and social communities should review their existing practice for the assessment and prevention of falls in older people against this guideline. The review should consider the resources required to implement the recommendations set out in the original guideline document and in the "Major Recommendations" section of this summary, the people and the processes involved, and the timeline over which full implementation is envisaged. It is in the interests of people at risk of falling that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways, and protocols should be reviewed in the light of this guidance and revised accordingly. Attention is drawn to the generic example in Appendix E of the NICE version of the original guideline document.

Specialist falls services may vary among providers in the detail of configuration, staffing, and leadership. The most cost-effective configuration is not yet established. Specialist falls services should, however, be operationally linked to both bone health (osteoporosis) services and cardiac pacing services.

This guideline should be used in conjunction with the National Service Framework for Older People (2001) in England and will support the implementation of Standard Six and Standard Two (Falls and Single Assessment Process) and Medicines management.

Audit

Suggested audit criteria are listed in Section 8 of the original guideline document. These can be used as the basis for local clinical audit, at the discretion of those in practice.

Principles of Practice

The principles outlined below describe the ideal context in which to implement the recommendations in the guideline. These have been adapted from the National Institute for Clinical Excellence (NICE) Clinical Guideline: Pressure Ulcer Prevention (2003).These principles went through a consensus process, were refined and published in order to describe the ideal context in which to implement guideline recommendations.

Person-centred Care

- Patients and carers should be made aware of the guideline and its recommendations and be referred to the Institute's Information for the Public.
- Patients and carers should be involved in shared decision making about individualised falls prevention strategies.
- Health professionals are advised to respect and incorporate the knowledge and experience of people who have been at long-term risk of falling and have been self-managing this risk.
- Patients and their carers should be informed about their risk of falling, especially when they are transferred between care settings or discharged home from hospital settings.

A Collaborative Multidisciplinary Approach to Care

- All members of the multidisciplinary team should be aware of the guidelines and all care should be documented in the patient's healthcare records.

Organisational Issues

- An integrated approach to falls prevention with a clear strategy and policy should be implemented. It should be closely and operationally linked to bone health (osteoporosis) and cardiac pacing services in such a way as to avoid duplication.
- Care should be delivered in a context of continuous quality improvement where improvements to care following guideline implementation are the subject of regular feedback and audit.
- Commitment to and availability of education and training are needed to ensure that all staff, regardless of profession, are given the opportunity to update their knowledge base and are able to implement the guideline recommendations.
- Patients should be cared for by personnel who have undergone appropriate training and who know how to initiate and maintain correct and suitable preventative measures. Staffing levels and skill mix should reflect the needs of patients.

IMPLEMENTATION TOOLS

Audit Criteria/Indicators
Clinical Algorithm
Patient Resources
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

National Collaborating Centre for Nursing and Supportive Care. Clinical practice guideline for the assessment and prevention of falls in older people. London (UK): National Institute for Clinical Excellence (NICE); 2004 Jun. 185 p.

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Jun

GUIDELINE DEVELOPER(S)

National Collaborating Centre for Nursing and Supportive Care - National Government Agency [Non-U.S.]

SOURCE(S) OF FUNDING

National Institute for Clinical Excellence (NICE)

GUIDELINE COMMITTEE

Guideline Development Group

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Guideline Development Group Members: Professor Gene Feder (Group leader) Department of General Practice & Primary Care, St Bartholomew's and the London Queen Mary's School of Medicine and Dentistry; Miss Margaret Clark, Alzheimer's Society; Dr Jacqueline Close, Royal College of Physicians, King's College Hospital, London; Dr Colin Cryer, Centre for Health Services Studies, University of Kent at Canterbury; Ms Carolyn Czoski-Murray, School of Health and Related Research, University of Sheffield; Mr David Green, Royal Pharmaceutical Society of Great Britain. The Pharmacy, Colchester Hospital; Dr Steve Illiffe, Royal College of General Practitioners, Department of Primary Care & Population Sciences, Royal Free Hospital; Professor Rose Anne Kenny, Institute for Health of the Elderly, University of Newcastle upon Tyne; Dr Chris McCabe, School of Health and Related Research, University of Sheffield; Mrs Eileen Mitchell, Clinical Effectiveness Forum for Allied Health Professionals, North Dorset Primary Care Trust; Dr Sarah Mitchell, Clinical Effectiveness Forum for Allied Health Professionals, Glasgow Royal Infirmary; Dr Peter Overstall, British Geriatrics Society. County Hospital, Hereford; Mrs Mary Preddy, National Osteoporosis Society; Professor Cameron Swift, King's College Hospital (Link Guideline Development Group member for the Osteoporosis Guideline); Mrs Deidre Wild, Royal College of Nursing

National Collaborating Centre for Nursing and Supportive Care: Ms Sue Boyt, Administrator; Ms Jacqueline Chandler-Oatts, Research Associate; Ms Elizabeth Gibbons, Research and Development Fellow; Dr Gill Harvey, Director; Ms Jo Hunter, Information Specialist; Ms Elizabeth McInnes, Senior Research and

Development Fellow; Ms Emma Nawrocki, Administrator; Mr Robin Snowball, Information Specialist (seconded from Cairns Library, John Radcliffe Hospital, Oxford); Mr Edward Weir, Centre Manager

Additional assistance: Dr Phil Alderson, Cochrane Centre, UK; Dr Lesley Gillespie, Cochrane, Musculo-skeletal injuries group, UK; Dr Lesley Smith, Centre for Statistics in Medicine

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

All members of the Guideline Development Group (GDG) were required to make formal declarations of interest at the outset, which were recorded. GDG members were also asked to declare interests at the beginning of each GDG meeting. This information is recorded in the meeting minutes and kept on file at the National Collaborating Centre for Nursing and Supportive Care (NCC-NSC).

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455, ref: N0247. 11 Strand, London, WC2N 5HR.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- National Collaborating Centre for Nursing and Supportive Care. Falls: the assessment and prevention of falls in older people. NICE guideline (Clinical guideline 21). London (UK): National Institute for Clinical Excellence (NICE); 2004 Nov. 29 p. Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.
- National Collaborating Centre for Nursing and Supportive Care. Falls: the assessment and prevention of falls in older people. Quick reference guide. London (UK): National Institute for Clinical Excellence (NICE); 2004 Nov. 2 p. Electronic copies: Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Additionally, Audit Criteria can be found in Section 8 of the original guideline document.

PATIENT RESOURCES

The following is available:

- Falls: the assessment and prevention of falls in older people. Understanding NICE guidance – information for older people, their families and carers, and the public. National Institute for Clinical Excellence (NICE), 2004 Nov. 24 p. Available in Portable Document Format (PDF) from the National Institute for Clinical Excellence (NICE) Web site.

Print copies: Available from the National Health Service (NHS) Response Line 0870 1555 455, ref N0761.

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This NGC summary was completed by ECRI on February 16, 2005. The information was verified by the guideline developer on March 7, 2005.

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